# Mental Health Services Of Catawba County

Draft Local Business Plan

January 2, 2003
(April 1, 2003 revision)

## Section I. Planning

Contact Person:
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# Local Business Plan: Strategic Plan Matrix

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|---|---|
| **Area Program(s)/County Program** | Mental Health Services of Catawba County |
| **Contact** | John M. Hardy, Area Director, (828)695-5900, fax (828)695-5949, johnh@catawbacountync.gov |
| **Submission Date** | 04/01/03 (revised from 01/02/03) |

**Item: I. Planning 1**

**Goal: The local business plan demonstrates congruence with the mission and principles of the State Plan.**

**Effective Date: 10/03**

| Steps Taken | Steps Planned | Barriers |
|---|---|---|
| Reviewed current mission statement for applicability to LME expectations. Quality Management Team and CFAC representatives developed a revised mission statement including philosophy, values and working principles. (Attachment A)<br><br>Product reviewed and approved by CFAC. | Review and approval by the Area Board<br><br>Ongoing education and orientation of stakeholders regarding values of area program/LME consistent with the mental health reform efforts.<br><br>Create QPN consistent with values set forth in mission statement, with expectations included/ communicated in orientation, RFP process and ongoing contractual relationships.<br><br>Annual analysis of mission statement and review of how each value is actualized with refinement as required. | |

**Reviewers Comments:**

**Attachment A –Philosophy and Mission Statement**

**PHILOSOPHY**

Mental Health Services of Catawba County assures the provision of quality services to people to promote the highest level of independence, self-sufficiency and productivity through the simplest measures of support. Recognizing consumers as individuals with all accompanying rights and responsibilities. MH Services promotes a partnership role that maximizes consumers' autonomy and choice.

**MISSION**

We serve individuals and families facing substantial challenges related to substance abuse, mental illness, or developmental disabilities. Our commitment is to promote a consumer-driven, outcome-based, family-centered system of services that is flexible, accessible, and which enhances the individual's freedom of choice. The service system empowers consumers to become as independent, self-sufficient, and productive as possible with least restrictive supports.

**VALUES** – *We support*

- Flexibility of services to be responsive to the needs of the individual
  - As evidenced by:
    - Soliciting consumer input and participation in continuous planning
    - Looking at times and locations of offered services, building in supports like transportation and childcare
    - Engaging caring providers fully trained in the practice of person-centered planning

- Accessibility to services and information that will enhance and improve the quality of life
  - As evidenced by:
    - Readily available transportation resources
    - Establishment of consumer handbook listing providers, service arrays, "report cards"
    - Strengthened prevention efforts throughout the community
    - Easy access to relevant diagnostic and clinical information as part of treatment involvement
    - Continually updated community supports references

- Partnership between consumers, families and providers based on trust, honesty, mutual respect, equal investment and involvement by promoting the opportunity for consumers and families to provide input and assume responsible roles in quality of care
  - As evidenced by:
    - Full participation of involved parties at all levels of decision making
    - CFAC involvement in service monitoring
    - Strong staff liaison with CFAC

- Excellence at all levels of daily operations, including the integrity that maintains high ethical standards
  - As evidenced by:
    - Continuous quality improvement process
    - Monitoring, provider and consumer surveys for data collection and tracking, appropriate credentialing of qualified/trained caring staff

- Individual choice and self-direction
  - As evidenced by:
    - Ongoing sensitivity to actual/potential barriers to client choice, with efforts to reduce the barriers
    - Sponsoring provider fairs
    - Adherence to person-centered planning as best practice

- Service design that moves people toward measurable outcomes in the most cost efficient manner
  - As evidenced by:
    - Alignment with best practice models
    - Cost analysis to determine efficiency expectations both clinically and financially

- Consumer rights
  - As evidenced by:
    - RFP requirement of providers to have established client rights committees with consumer involvement and regular submission of minutes to the LME
    - Adherence to complaint/grievance policy and procedures
    - Ongoing prioritization of client rights training/practice at all levels of service provision

- Community integration by connecting people with natural supports, community resources and employment
  - As evidenced by:
    - Provider and consumer education on community supports
    - Community education to enlist and engage natural supports more readily
    - LME role as liaison with community to encourage providers and community organizations to employ consumers

- Ongoing local community planning, coordination and responsible management of public policy
  - As evidenced by:
    - Maximum involvement and use of existing boards (Board of Commissioners, Area Board) and further encouraging input From CFAC and Client Rights Committees

- Provider engagement in development of best practices, policies and methods to meet consumer needs
  - As evidenced by:
    - Contracting processes including training and technical assistance
    - Peer or panel review process

**WORKING PRINCIPLES** – *We expect all participants*

To assure service environments that reflect respect and caring for consumers and families

To advocate for rights and needs of consumers

To engage the “Best Practices” available to move consumers towards “best outcomes”

To be as actively involved as much as possible

To ensure cultural competency and cultural sensitivity at every level

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| **Contact** | John M. Hardy, Area Director, (828)695-5900, fax (828)695-5949, johnh@catawbacountync.gov |
| **Submission Date** | 01/02/03 |

**Item: I. Planning 2a**

**Goal: The local business plan planning process meets State Plan requirements.**

**Effective Date: 10/03**

| Steps Taken | Steps Planned | Barriers |
|---|---|---|
| Identified strengths and weaknesses of current configuration of area program based upon specific feedback from CFAC, multiple community forums, provider surveys and internal review. | Designate steps to build upon strengths and ameliorate weaknesses.<br><br>Continue forums and solicitation of public comment on local business plan for ready access to feedback on strengths, weaknesses, and planning process as a whole ongoing goal | |
| <u>Strengths</u> | <u>Building on Strengths</u> | |
| Strong county government support both with direct financial support and indirect support in facility maintenance, vehicle maintenance, legal services, human resource management, risk management, and liability coverage. | Maintain ties and communication that foster strong partnership and commitment to county citizens. Keep governmental leadership involved in discussions around contacts with surrounding area programs regarding LME roles/efforts. | Resolve the lost impact of indirect expenditures from Catawba County that support Mental Health Services at $900,000 per year. There is also the potential loss of 2 million dollars due to the loss of Fund Balance. |

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| Stable management and clinical personnel of the area program | Stability will assist in transition to LME management roles and provision of clinical services in the community. Prioritize efforts at clear communication in transitional planning that maximize retention and expansion of qualified professional staff in the local community | |
| Well-established community relations | Strong base to continue to build QPN and enhance community supports. Look at existing community providers for expansion of service array, or development of new service entities. Assure ongoing meetings with providers and community stakeholders. | |
| Physical facilities appropriate for specialized populations served | Designate available financial resources to assure permanency of appropriate facilities for specialized service delivery within the community (i.e., constructing new facility for ADVP program). In divestiture plan make facility available for external provider utilization in RFP process. | Current space for ADVP program is in limited lease arrangement.<br>Psycho-social clubhouse site/facility involves a 50 year lease in conjunction with the Historical Society and Catawba County Government.<br>Residential facilities and transportation are owned and maintained by county government. These include 65 group home and apartment beds for MH and DD consumers and 18 vans that travel over 750,000 miles per year. Additional cost will be incurred by outside provider to supply comparable components. |
| Proven track record with ability to meet performance contract expectations in administrative realm, strong MIS and financial management history. | Look at contracting possibilities with other programs in functions such as claims adjudication, UM, etc. Maximize economies of scale where possible. | Awaiting state financial model to determine cost effectiveness |
| Stable and involved Area Board who take an active role in the management of the agency. | Continue Board training and involvement in planning. | |

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| Currently contract 26.9% of direct services. | Expand contracting process through development of QPN. Build on established practices of oversight and tracking necessary to meet needs of greater contract base. | Lack of financial support for providers to contract for services, particularly with adult MH and SA clients. Concern about risk and lack of financially beneficial funding sources with this population. |
| Attention to staff concerns | Continued communication with staff regarding transition phases toward LME role | |
| Ability to pursue funding from private foundations due to establishment of separate non-profit entity | Expand grant pursuit to meet needs of organizations contracting with area program for client services | Economic considerations – less funds available. |
| Approximately 27,000 people from other neighboring counties flow into Catawba County for employment. We provide services to 120 out -of - county citizens | Increase collaborative efforts to assure citizens are provided services and economies of scale are maximized whenever possible. | |
| <u>Weaknesses</u> | <u>Addressing Weaknesses</u> | |
| Services provided to only 9.9% of individuals aged 55 or older compared to statewide average of 19%. This population represents 21.8% of Catawba County's total census. | Improve outreach efforts to existing supports for this age group involving education about mental illness and available services. Once population is identified do needs assessment for specialized services. Focus on developing and strengthening community supports. | Population often reluctant to seek services, believe that stigma is attached. |
| Hispanic/Latino and Asians represent 9.8% of the Catawba County census and make up only 2.3% of clients served. One exception is service to Hispanic/Latino clients age 10-17, served at a rate of 22.4% compared to the state average of 14.5%. | Similar efforts as listed above with addition of materials and outreach provided in language and culturally-tailored manner. Focus efforts at developing community supports and provi ders. Continue and expand training efforts on cultural diversity. Continue to seek representation on CFAC | Language barriers and cultural differences regarding mental health care. Lack of clinical providers representing multiple cultures. |
| Lack of advocacy groups in the community | Continue support and strengthening of CFAC, encouraging that membership to become familiar with both formal and informal advocacy opportunities. Explore incorporating CFAC into organizational structure with potential linkages to | Historically have tried grass roots efforts that have not been successful in developing local NAMI or ARC chapters. There have not been any major issues for advocacy groups to rally around. |

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| | client rights committee and grievance procedures/processes for providers or consumers, and existing interagency forums. | |
| Limited use of outcome measures for planning and evaluation historically | Identify outcome measurement tools, tracking mechanisms and application of aggregate data for planning purposes. | Need for designated staff and attached funding for position on outcome tracking. State has yet to identify and standardize outcome measurement tools. |
| Lack of crisis stabilization beds in the community, along with limited partial hospitalization programs and high maintenance group homes. | Build on needs assessment to determine level of demand, including neighboring area programs to look at feasibility of regional services. Once determined post RFI if applicable. | Funding mechanism and facility availability. The current reduction as well as future planned reductions in in-patient hospital beds in the Western Region. |
| Public transportation is limited, allowing clients few resources to access services independently. In addition transportation currently provided by county program which will change as we transition to an LME. | Compile list of transportation provided by area program for RFP purposes, making transportation availability a necessary component in selected service provision.<br>Explore expansion of public transportation resources, routes, etc.<br>Explore establishment of independent transportation sources. | Funding availability and provider capacity |
| Increase in number of rest homes in the community disproportionate to staffing availability to meet client needs | Establish baseline of mental health clients currently served in rest home environments along with service needs. Educate and involve community rest home providers on process to access needed mental health services. Provide training on mental health issues. | No regulatory requirements (certificate of need) for establishment of rest homes, so no proactive assessment of service capacity to determine sufficiency for consumers brought into the community. Current staffing pattern and lack of funding will not support services as they are requested. |
| Recent decrease in job opportunities for consumers | Explore employment opportunities for consumers in RFP of QPN, and look within the LME organizational structure for consumer employment opportunities<br><br>Educate the community on job coaching benefits to employer | County unemployment rate of 9.2% in July 2002 |

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**Reviewers Comments:**

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| **Submission Date** | 04/01/03 (revised from 01/02/03) |
| | |

**Item: I. Planning 2b**

**Goal: The local business plan planning process meets State Plan requirements.**

**Effective Date: 10/03**

| Steps Taken | Steps Planned | Barriers |
|---|---|---|
| Established policy for formation of local CFAC with approval by local Area Board (Attachment B)<br><br>Recruited members for CFAC through nominations from area staff and community members<br><br>Designated staff liaison to CFAC<br><br>Held orientation meeting with members of CFAC for education purposes and establishment of roles and responsibilities in reform process<br><br>CFAC developed procedures for operation of their committee.<br><br>Members elected Chair and Vice-Chair | Continue providing support to CFAC<br><br>Involve CFAC members in all levels of reform planning<br><br>After discussion of NC Council conference in Pinehurst and the area program's offer to sponsor two members of CFAC to attend, the CFAC committee decided instead to utilize the funding to host a Western Regional CFAC training conference locally. The CFAC members will query the surrounding area program CFACs on what topics would be beneficial for training and will plan the event.<br><br>Support CFAC in establishment of relationships with | Need to determine if stipends will over-inflate income and endanger consumers' benefits.<br><br>CFAC members have expressed concerns over how the proposed changes will impact current services.<br><br>Cost to the LME for stipends, meals, transportation, childcare, translators, interpreters, etc. |

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| Members established meeting frequency of 3 times monthly<br><br>CFAC sponsored consumer forum to gather input for completion of needs assessment<br><br>Three CFAC members are on the Planning Committee for developing the local business plan for MH reform.<br><br>We have been able to include a hearing-impaired consumer as an active member of CFAC since January 2003<br><br>Sent CFAC member who was the recipient of NC Council scholarship to Pinehurst to attend Consumer sessions to provide feedback to the CFAC as a whole<br><br>MHSCC has allocated $1500 to CFAC for a regional CFAC meeting to be held in the future<br><br>CFAC hosted representatives from The Arc of NC and NAMI to explore advocacy opportunities and the possibility of establishing local chapters of these organizations | the Division and regional CFAC groups.<br><br>Support CFAC interagency involvement<br><br>Support goals of the CFAC through financial and staff support. Continue to explore other financial supports for these efforts (e.g., NC Council has agreed to help financially sponsor the regional CFAC workshop scheduled for spring 2003)<br><br>Determine how CFAC members will be involved in task of each sub-committee as outlined for local business plan development and implementation.<br><br>CFAC-sponsored forum to be held to educate the community on MH Reform and the impact that will be felt in Catawba County | |

| **Reviewers Comments:** |
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**Attachment B – Consumer and Family Advisory Committee Policy**

Attachment B – Consumer and Family Advisory Committee Policy – Planning

Mental Health Services of Catawba County

**POLICIES AND PROCEDURES**

ACTIVITY: GENERAL ADMINISTRATION

SUBJECT: CONSUMER AND FAMILY ADVISORY COMMITTEE

Number: 1.053
Effective Date: 08/15/02
Amended Effective:
Board Approved: 08/15/02
QMT Approved: 08/09/02

POLICY:

The Mental Health Services of Catawba County (MHSCC) Board establishes a Consumer and Family Advisory Committee (CFAC) as required by House Bill 381 and as outlined in North Carolina's State Plan for Reform of Mental Health, Developmental Disabilities, and Substance Abuse Services. The CFAC will provide advice and recommendations to the Area Board and staff regarding the local business planning effort including submission of required Division reports and on-going consumer input into the operation of the Local Managing Entity **(**LME).

PROCEDURE:

A. Method

1. The Area Director will select an employee of the Area Program to be the liaison between the CFAC and the Area Program. The CFAC Liaison will:
   Obtain consumer and family input from the community
   Carry forward recommendations of the CFAC for implementation
   Serve as the liaison to the state advisory committee and other local agencies, organizations and associations
   Recruit the initial CFAC members in collaboration with local consumers and consumer groups

2. The CFAC will have a membership composed as follows:
   100 percent consumer and family membership
   Equal representation of all disability groups
   Race and ethnicity membership representative of the community
   Representatives from each disability group including a man, a woman and a youth.
   Family members may represent children
   A parent may represent the needs of parents of adult consumers
   CFAC liaison will serve as an ex-officio, non-voting member
   Maximum of 15 voting members

B. Training and Orientation

1. Each CFAC member will receive training and orientation regarding the role and responsibility of the CFAC. All applicable statutes, codes, and local policies will be available to committee members.

Attachment B – Consumer and Family Advisory Committee Policy – Planning

Mental Health Services of Catawba County

**POLICIES AND PROCEDURES**

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ACTIVITY: GENERAL ADMINISTRATION SUBJECT: CONSUMER AND FAMILY ADVISORY COMMITTEE

EFFECTIVE: 08/15/02 AMENDED:
NUMBER:

C. Meeting/Voting

1. The CFAC will meet monthly and more often if needed.
2. Quorums, voting, and business conducted shall follow Robert's Rules of Order.

D. Terms and Appointment

1. The initial committee members will serve one year with the option of being reappointed by the Area Board for a 2-year term. They will have the option of serving one additional term. The initial term of office will be from August 2002 – July 2003.
2. New members will be recruited to maintain required committee representation.
3. The CFAC committee will select and forward potential member names to Area Board for committee appointment.

E. Attendance

1. If a member misses three consecutive meetings without notification, they may be removed from the committee. Removal of a member for non-attendance will be made official by a majority vote of the committee and approval of the Area Board.

F. Officers

1. The Committee will elect a Chairperson and annually elect a Vice–Chairperson. Officers will serve a one-year term unless they are filling the remainder of an un-expired term.
2. Elections will be held in June. Officers will take office in July.
3. The Vice-Chairperson will serve in place of the Chairperson if the Chairperson is unavailable or unable to serve. If the Vice-Chairperson completes the unfilled term of the Chairperson the Vice-Chairperson will also be eligible to serve one additional year as Chairperson.
4. The Vice-Chairperson will serve as the Chairperson at the end of the Chairperson's term.

G. Confidentiality

1. CFAC members will strictly guard the confidentiality of all clients and will be required to sign an Assurance of Confidentiality form upon formation of the committee and then on an annual basis as required by the agency's national accreditation.

Attachment B – Consumer and Family Advisory Committee Policy – Planning

Mental Health Services of Catawba County

**POLICIES AND PROCEDURES**

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ACTIVITY: GENERAL ADMINISTRATION SUBJECT: CONSUMER AND FAMILY ADVISORY COMMITTEE

EFFECTIVE: 08/15/02 AMENDED:
NUMBER:

H. Roles and Responsibilities

1. Advise and comment on the Area Program's business plan
2. Make recommendations on areas of service eligibility and service array, including identification of service gaps
3. Assist in the identification of under-served populations
4. Provide advice and consultation regarding the development of additional services and new models of service
5. Participate in monitoring service development and delivery
6. Review and comment on the local service budget
7. Observe and report on the implementation of state and local business plans
8. Participate in all quality improvement projects at both the provider and LME levels
9. Ensure consumer and family participation in all quality improvement projects at both the provider and LME levels

I. CFAC Recommendations

1. CFAC minutes and any recommendations related to the local business planning process will be forwarded to the Area Program State Planning Committee in a timely manner.

J. CFAC Reports

1. The CFAC will review the local business plan and make a separate report to the Division.
2. The CFAC will review and report to the Division on the following planning areas:
   - Service Management – strengths and weaknesses of the management plan for oversight and operation of core service functions
   - Access to Care – documented review of exceptions to 30-mile/minute provision
   - Collaboration – letter of endorsement or report of concern related to plan for community collaboration efforts

K. CFAC Support System

1. The Area Program/LME will consider reasonable supports to eliminate barriers in an effort to ensure consumer/family participation and viability of the CFAC.

HISTORY NOTE: New policy developed for MH System Reform. Approved by the Quality Management Team **on 08/09/02**. Approved by the Consumer and Family Advisory Committee on 8/21/02. Approved by the Mental Health Board on 08/15/02.

# Local Business Plan: Strategic Plan Matrix

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| **Contact** | John M. Hardy, Area Director, (828)695-5900, fax (828)695-5949, johnh@catawbacountync.gov |
| **Submission Date** | 01/02/03 |
| | |

**Item: I. Planning 2c**

**Goal: The local business plan planning process meets State Plan requirements.**

**Effective Date: 01/03**

| Steps Taken | Steps Planned | Barriers |
|---|---|---|
| Developed statement regarding commitment to consumer/stakeholder involvement<br><br>Statement confirmed by CFAC (Attachment C)<br><br>Statement<br><br>Mental Health Services of Catawba County is committed to consumer/stakeholder involvement consistent with State Plan initiatives. This commitment includes establishment of a Consumer and Family Advisory Committee. The agency provides supports necessary to ensure that consumers and family members are able to fully participate in the planning and management process | Continued communication with the broader community about state mental health reform and local business planning process. Provide current information through internet, public service announcements, community forums, open board meetings, etc. Widely publicize venues of providing feedback and active participation. (Contact number and person within the agency.) | Cultural issues and language barriers make it difficult to bring all stakeholders to the table. |

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| as developed in the LME role. Broad representation from the community is welcomed and encouraged through the open door policy and establishment of forums and other public meetings to solicit participation. Community participation includes local government representatives, county citizens and providers.<br><br>Posted first 5 sections of local business plan on county web site for local review and comment. | | |

| **Reviewers Comments:** |
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**Attachment C - 11/06/02 CFAC minutes**

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Consumer and Family Advisory Committee
November 6, 2002

Present: Hether H., Janet L., Sennie S., Patrick R., Paula W., Mary R., Kathy L., Tony B.

Absent: Chip J., Larry P., Mike T., Warren W., Denise L.

Staff present: John Waters, Doug Gallion, Melanie Britt and Gail Henson

In the absence of Chip J. and Denise L., Paula W. called the meeting to order at 6:05 p.m. and welcomed everyone.

Minutes from 10/30/02 were reviewed and approved on a motion from Janet L.

Paula requested everyone to introduce themselves to our new member Patrick. Patrick is replacing Mike T.

Paula introduced Melanie Britt, Local Business Planning Steering Committee member to present the section of the LBP on Planning. The Planning section involves all stakeholders in the process of restructuring our agency from a provider of services to a manager of services. This included the steps of redesigning the mission, vision and values of the agency. The CFAC members were involved in this process. The Planning section also included an analysis of the strengths and weaknesses of our area program as it is currently operated. A noted weakness was the need to increase outreach to the Hispanic community and to those individuals over the age of 55. The planning section involved the development of the CFAC.

Melanie shared with the committee the required statement on stakeholder involvement. A motion was made by Tony to accept the stakeholder statement as presented. All present concurred and the statement was approved.

Questions were raised and concerns were noted as follows:

1. Kathy wants to be sure there is more family and consumer participation.
2. Tony stated that if there had been more family involvement over the last 10 years or so then families may have been better able to keep involved with the individual with mental illness. This is based upon the understanding that if a consumer has problems then the family also has a problem.
3. Tony also questioned how would we communicate the stakeholder statement to the community. Melanie stated the statement itself would not be shared with the community but that the agency would actualize the statement through various methods of gathering input.
4. Sennie stated that a problem with family members being involved with the consumer is due to transportation and she wondered if the agency may look at methods to provide transportation to family members so they can learn more about mental illness. This could also involve workshops, presentations, etc. on mental illness, developmental disabilities or substance abuse issues.
5. The committee noted that some of the barriers to people participating in meetings and forums are childcare, transportation and time of meetings. The CFAC and the agency will note these barriers and determine how to best limit them.

John Waters noted that the CFAC may choose to have another forum in December if they desire as we have the rooms reserved. He also requested that the CFAC members let him know who wants to attend the MH Board meeting on November 21st to present the committee response to the first sections of the local business plan.

Melanie reviewed the draft divestiture plan that was previously presented by John Hardy. There had been minor changes including the addition of the Respite contract and the modifying of the dates for the divestiture of the MH Residential, Connections, CSP program.

Paula introduced Gordon Cappelletty to present the section on collaboration. He stated that this section would be the most important in convincing the Division that we have the means to remain a single county program. The CFAC will be required to submit a letter stating their endorsement of the plan as written or attaching their concerns.

Dr. Cappelletty described the collaboration process to involve public agencies, faith based organizations, support groups and others who have an interest in mental illness, developmental disabilities or substance abuse. He requested the committee share with him ideas of other organizations he can contact.

Tony stated that previously consumers had not been asked for their input. He also felt that consumers need to be educated as to the value of their input. They need to know that this will help them strive for self-determination and the ability to assist themselves.

A concern was noted that some faith-based organizations do not truly believe in mental illness and may encourage people to just pray out their illness. Tony stated that the current NA/AA manual states an individual with emotional or mental issues most likely will not be able to solve their substance abuse problems. Staff shared with the committee that if we contract with faith based organizations they will not be able to mandate that a participant share in the religious portion of the program. Hether shared how when a coalition of churches come together they can offer support to those in need without mandating a religious focus.

Gordon discussed the fact that Catawba County does not currently have any advocacy groups mainly due to a lack of a major concern in the community. We do have a consumer run advocacy group at Connections. The group is New Beginnings and one of our goals will be to encourage the expansion of the program. Gordon mentioned that one of the roles of the LME will be to provide assistance to advocacy groups including financial and technical support.

Tony mentioned that it would benefit the New Beginnings group to have more speakers around the issues of mental illness. He also requested access to a meeting room so they can reach more people outside the clubhouse. An issue brought up by other committee members was that there may be a need for transportation and childcare in order to facilitate better participation in the meetings. The mission statement from New Beginnings was shared with the committee.

Gordon continued his presentation with a description of silos and the desire to eliminate as many of them as possible. Silos are where funding streams and services are limited in their flexibility to move across disabilities. The CFAC is an example of eliminating silos through the representation of people across disabilities.

Gordon discussed the system of care for children and Hether voiced a concern that money and political issues affect this concept. She also noted that there are limited number of doctors who will take Medicaid patients and this limits the quality of care. She suggested that doctors volunteer to serve a number of Medicaid patients in order to provide quality care. This is an issue across all ages and disabilities as noted by Sennie and others on the committee.

Doug Gallion presented his final section on evaluation. Tony questioned whether the clubhouse needed to keep ICCD accreditation since it limits the ability to have a profit making business and to have consumer run advocacy groups.

John Waters shared with the group that the NC Council is offering 8 scholarships across the state to consumers to attend the workshop in Pinehurst Dec. 9 and 10th. The sessions would be focused on consumer run organizations. The committee requested that John Waters complete an application for Tony to attend the conference.

It was announced that the request for $1500 for a regional conference had been approved.

The next meeting will focus on development of the report to be submitted to the MH Board and to the Division.

There being no further business the meeting adjourned at 8:15 p.m.

Respectfully submitted,

Gail A. Henson, M.Ed.

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| **Submission Date** | 04/01/03 (revised from 01/02/03) |
| | |

**Item: I. Planning 2d**

**Goal: The local business plan planning process meets State Plan requirements.**

**Effective Date: 04/03**

| Steps Taken | Steps Planned | Barriers |
|---|---|---|
| Ongoing involvement of Area Board in development of local business plan<br><br>Obtained formal resolution from the governing body accepting the local business plan as submitted – first submission in 04/03 (Attachment D) | | Awaiting state deliverables necessary for comprehensive local business plan scheduled to meet full initial certification application for Phase III. |

**Reviewers Comments:**

**Attachment D – MHSCC Board minutes for 02/20/03**

**Minutes**
**Mental Health Services of Catawba Board of Directors**
**February 20, 2003**
**7:00 P.M.**

The Mental Health Services of Catawba County Board of Directors met for its monthly meeting on this date at the main Mental Health Center.

Members present included:, Barbara G. Beatty, David Boone, Lora Holman, David Isenhower, Karen Lane, Dr. Tom McKean, Steve Sayers, and Harold Setzer. Excused and/or absent for other equivalent circumstances were Susan Anderson , Fred Bryson, Steve Graff , Martha Palmer, and Dr. Robert Yapundich. Staff present included John Hardy, Area Director; Sonja Bess, Administrative Services Manager; Melanie Britt, Staff Trainer; and Brenda Teague, Administrative Assistant. County Commissioner Dan Hunsucker was also present.

Chairman David Isenhower called the meeting to order at 7:10 p.m. and welcomed all present.

Invocation

Harold Setzer led the **Invocation.**

Minutes

The Minutes of the January 30, 2003 Mental Health Board Meeting were presented.

Karen Lane made a motion that the January 30, 2003 minutes be approved as corrected, and David Boone seconded the motion.

There was no further discussion.

The motion was approved.

Citizens Comments

There were no **Citizens Comments**.

**Presentation**

Dan Hunsucker was presented with a plaque by Chairman David Isenhower recognizing his service to the Mental Health Board .

Commissioner Comments

Shared information:

1.From a local meeting on Mental Health Reform she attended on February 19.
Recent action taken by the County Commission

Director's Report

Personnel changes and efforts during the past month.
Ernest Williams has been assigned our project manager for the Life Skills Building
Judge's Luncheon held on February 13, 2003.
Performance Agreement Report.

Consideration Items

**Board Composition**. It was recommended that the Board identify those categories of members that need to be filled to satisfy the new law requirements. It appeared that three additional members need to be added to the Board in the consumer categories. Currently, there are two vacancies on the Board with a current composition of 15. Change in the law requires that the Board reflect a different composition, with a greater emphasis on consumer and family member participation. The attached inventory of current Board members shows the deficit that needs attention. The net impact would be to expand the Board to 17 members. Currently, two of the openly declared consumer slots have been filled and that information has been submitted to Commissioner Beatty. Harold Setzer has a recommendation to fill the last openly declared consumer slot and will get that information to the Clerk . It was suggested to Commissioner Beatty that she hold the two appointments she currently holds until she receives the third.

David Boone made a motion that the Board change its composition from 15 member board to a 17 member board, and it was seconded by Dr. Tom McKean.

A member at large appointment seemed to be the most appropriate category for the 17th slot on the Board. Someone with a wider scope within the county would be a good choice.

The motion was approved.

**Life Skills Building**. Director Hardy explained the schematic plan of the Life Skills building and addressed the concerns and questions the Board members had. A letter from the Project Architect, Wesley Curtis, was distributed to the Board that noted preliminary estimates at this point for the cost to be approximately $100/per SF. The building SF is approximately 15,200 SF for an estimated cost at this point to be $1,520,000 and additionally there is a remote parking lot estimated at $225,000. The additional parking lot will be located behind the current Health Department. The County felt that while machinery is in moving dirt for this building they manage this additional parking as well. We are talking with CVCC landscaping class and are asking that they come up with a proposal for the outside area. We will offer a prize for the idea selected. There will be computers in every classroom. Each classroom will hold 6-8 people including staff. Currently we have 35-38 on roll. With the numbers we are aware of coming out of Conover School within the next three years we will be at capacity. The new space will hold 50-55. The process for the construction was shared.

A motion was made by Karen Lane that the Board adopt this plan for the Life Skills Building as presented and that it be presented to the Board of County Commissioners, and it was seconded by Dr. Tom McKean.

There was no discussion.

The motion was approved.

Action Items

**Local Business Plan – Part II**. Ten parts are needed to be submitted to the State on the Local Business Plan for Mental Health Reform. Five were submitted by January 1 and the second five are to be submitted by April 1. Staff has put much effort into answering the required sections. The CFAC has received presentations and reviewed each section, giving its endorsement. The Board was asked to review and approve the submission of the second set of responses. Melanie Britt gave an overview of the last five parts. You have already approved we move to implement this plan in Phase III to begin July 1, 2004. We will be providing quarterly updates to the State. To date we have received no feedback from the state on the first five parts submitted. Ms. Britt addressed concerns and questions from the Board.

Dr. Tom McKean made a motion that the Board accept Part II of the Local Business Plan as presented, and it was seconded by Harold Setzer.

There was no further discussion.

The motion was approved.

2. **2003-2004 Budget**. The Budget/Finance Committee reviewed the 2003-2004 budget in much detail at its meeting on February 13 and recommended to the full Board that the 2004 budget be accepted as presented. David Isenhower in the absence of the Chair Steve Graff made this recommendation. The fiscal impact was a $14,639,809 budget. The budget very simply continued some of the cuts that were initiated in the current year. It anticipates a minus 0.2 percent growth, increased the application of fund balance dollars, realized a loss in County dollars, and some expansion in the use of Medicaid funds. It anticipated that there would be reasonable fund balance generated at the end of this year and that current State budget problems could have a large impact, not yet known. This was a no growth budget with increases occuring only from a 2 percent cost of living and lump sum performance pay for staff, significant change has occurred in specific areas and those adjustments are annualized in the budget. Changes resulting from lost revenue in FY 2003 included:

CAP-MR/DD – 3 case managers positions
Substance Abuse, detoxification services discontinued and shifted to contracts with the local hospital and other facilities; 10.5 positions eliminated; substance abuse outpatient services and merged with Counseling Services resulting in a loss of three support staff positions.
Counseling and Substance Abuse Services – one outpatient therapist and one supervisor position were eliminated
Residential, CBA and CSP positions for both residential and CSP efforts merged into one team, outpatient and case management units; 1 CBS Habilitation Technician, 1 case manager and 1 supervisor position eliminated
Smart Start – 1 half time psychologist position eliminated
Other adjustments consist of transitioning services to contracted service providers with projections based on current service activity level and any new anticipated activity for next fiscal year. these increases are funded with Medicaid dollars and new State dollars allocated for Community Capacity for mentally Ill Adults ($154,944) for developing and providing services for individuals returning to the community as a result of the planned closure of State Hospital units and in Substance Abuse for purchasing detoxification services ($236,000) from persons in need of those services.

There was an anticipated loss in State MR/MI and Comprehensive Treatment Services funds, as Medicaid becomes a larger funding source for many of these services.

Fund balance was applied at a significantly greater rate than in the current budget in order to balance against losses in other revenue sources, and there was a 5 percent net loss in County Share of $59,107.

General administration and area administration cost centers are merged into a single cost center and overhead (support staff and general operating expenses) was redistributed to direct care cost centers to align with State definitions for administrative expenses and to comply with allowable overhead (13 percent of budget) set by the Division of MHDDSAS.

Additional information on our three major contract agencies with regard to the budget for 2004 not available to the Budget/Finance Committee was a comparison of current contracted amounts and what is being proposed for 2004. The director had a meeting with the Flynn Homes several months ago and shared with them his thoughts on where we would be budgetarily for 2004 with them. They were not surprised. Speculation is that they have secured funding to replace Mental Health reductions for 2004. Director Hardy will verify this.

Harold Setzer made a motion that the Board accept the 2004 budget as presented, and it was seconded by David Boone.

There was no further discussion.

The motion was approved.

**Budget Revision for 2003**. A recommendation was made by the Budget/Finance Committee that the Board accept a budget revision in the amount of $966,381 increase to our current budget. This would bring our budget up to $15,636,193. The mid year revision reflected some new efforts funded by Medicaid as well as some grants that were anticipated but not realized until recently. The increases are in State Funds ($296,801):

Community Capacity funding - $ 63,340
Substance abuse Revenue - $102,660
MRMI Division Dollars - $130,801

Grants - $115,595

Juvenile Justice Delinquency Prevention - $11,297
Administrative Office of the Courts - $20,000
Criminal Justice Partnership Program - $84,298

Medicaid - $553,985

Psychosocial Rehabilitation - $110,000
Residential and CBS Services - $280,000
CBS Services - $190,000
Medicaid reduction in the ACT Team – ($26,015)

This revision added no new positions and requested no additional county dollars.

Steve Sayers made a motion that the budget revision increase the budget by $966,381 be accepted as presented, and it was seconded by David Boone.

There was no further discussion.

The motion was approved.

**Board Bylaws**. Historically, the Board's bylaws were part of the Catawba County Code. It has been recommended by the County Attorney that the Code only reflect the fact that the Board of Commissioners appoints the Area Authority as outlined in G.S. 122C. Bylaws that outline the operation of the Board would then be a part of agency policy and procedures. This change provides the opportunity to update those bylaws and to make any modifications the Board wishes. These were presented at the last meeting as a Consideration Item. The policy was again being presented. It was noted the issue around attendance had been added as requested.

It may also be noted that there was no where in the policy does it reflect that we will follow Roberts Rules of Order nor the procedure for how the Bylaws are changed by the Board.

Karen Lane made a motion that the Board accept this new policy as presented, and it was seconded by Harold Setzer.

There was no other discussion.

The motion was approved.

**Write-offs**. Distributed was a summary of accounts two-year-old that needed to be written off. They had been deemed uncollectable. The debts are spread across four major services cities and have been deemed uncollectable due to the status of the client; either unable to locate, deceased, nor response or unable to pay at all or incarcerated. The impact is $43,239.91. A summary of the accounts was detailed for the Board's information. The director recommended the acceptance of these write offs.

Steve Sayers made a motion that the Board write off $43,239.91 in uncollectable accounts, and it was seconded by Dr. Tom McKean.

There was no further discussion.

The motion was approved.

6. **Quarterly Reports for the Second Quarter.** Financial Report. Financial figures are on target for this quarter. Client Service Statistics. This information showed an impact of program reductions due to the closing of the Recovery Center and reducing staff expenditures. In addition, there indicated some staff turnover reduced capacity also during the quarter. Reimbursement Report. Very strong collection was seen in this quarter. This was clearly an over collection in this quarter due to lower collections in previous quarter. Total dollars billed were less due to service reductions.

Information Items

Informational items shared with the Board in their mailing or distributed on this date included:

Commissioner Synopsis for the February 3 and 17, 2003 meetings.
Connections Newsletter for February
Employee news update
NC Council Community News Update for January 2003

The next meeting of the Board will be held on March 20, 2003 at 7:00 p.m. at the main center.

As there was no further discussion, the meeting adjourned at 9:00 p.m.

Respectfully submitted,

Brenda W. Teague CPS
Clerk to the Board

Attachments: Noted above

# Local Business Plan: Strategic Plan Matrix

| | |
|---|---|
| **Area Program(s)/County Program** | Mental Health Services of Catawba County |
| **Contact** | John M. Hardy, Area Director, (828)695-5900, fax (828)695-5949, johnh@catawbacountync.gov |
| **Submission Date** | 04/01/03 (revised from 01/02/03) |
| | |

**Item: I. Planning 2e**

**Goal: The local business plan planning process meets State Plan requirements.**

**Effective Date: 04/03**

| Steps Taken | Steps Planned | Barriers |
|---|---|---|
| The local CFAC has been involved in the planning process and reviewing of materials to be submitted in January 03 and April 03. Minutes of each meeting have been retained to document both education of CFAC members and feedback to the sub-committees.<br><br>Three members of the CFAC are on the Planning Committee.<br><br>Sub-committee chairs presented to the CFAC the five sections due in January and incorporated the suggested revisions in the final document. | Continue to keep CFAC involved and updated on quarterly revisions to the local business strategic plan. | It is difficult to find convenient meeting times for all parties involved in the planning process.<br><br>The complexity of the local business plan requirements presents a difficulty for some members of the CFAC.<br><br>Delay in establishment of state CFAC is discouraging for local CFAC members as they strive to determine the communication process. |

| | | |
|---|---|---|
| Sub-committee chairs presented to the CFAC the five sections due in April and updates from the first five sections, incorporating the suggested revisions and feedback. CFAC completed a report concerning the comprehensive local business strategic plan. (Attachment E) | | |

| **Reviewers Comments:** |
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**Attachment E – CFAC Report**

February 12, 2003

Secretary Carmen Hooker Odom, and
Dr. Richard Visingardi, Deputy Director
Department of DHHS
3001 Mail Service Center
Raleigh, NC 27699-3001

Dear Secretary Odom and Dr. Visingardi:

Our committee has been organized for over six months. We have been meeting weekly but starting February 12, 2003 we will meet bi-monthly. We have been involved in the planning process and still share our concerns with the committee as a whole. We continue to meet and have a more detailed understanding of our role as CFAC. Since our last report one member attended the Pinehurst Conference and NAMI and the ARC of North Carolina made presentations to our Committee. We have learned more about the state reform, advocacy, and consumer involvement in the state plan for reform.

We have added a deaf consumer with her interpreter and we are learning more of their culture and ways of communicating with the world. We continue to learn from one another and grow in the experiences we share with each other. We are more aware as to what each groups disability needs are.

We support Catawba Mental Health in continuing to provide the same services at the level of excellence we have become accustomed to. We also support going from phase II to phase III; because as a consumer group we would acquire more time to obtain practical experience in becoming advocates for other consumers and family members in the reform process.

We were presented the Access To Care, Service Management, Financial Management and Accountability, Information Systems and Data Management and Governance, Management and Administration sections from qualified staff and would like to offer our input on the two sections we are required to report on: Service Management and Access To Care.

CFAC invited the staff members to give a detailed description of the two sections on two separate occasions. We had an intense open dialogue about service management and access. We believe that the partnership between CFAC and staff has established a strong rapport and working relationship.

## ACCESS TO CARE

We believe there would be adequate access to services. CFAC strongly supports consumer involvement in access to care.

CFAC feels there should be transportation to access sites, screenings, assessments, and referrals.

Secretary Carmon Hooker Odom
Richard J. Visingardi, Director
February 12, 2003

## ACCESS TO CARE

CFAC believes there should be increased public awareness of how to get mental health help.

We feel access and service management would be better served if there were emergency services that include adequate short-term crisis beds.

## SERVICE MANAGEMENT

We believe that consumers should have a strong role in identifying which service providers use best practice models of care.

CFAC of Catawba County will host a Consumer Forum on March 26, 2003 to provide updated information about Catawba County's plan for Mental Health Reform.

Sincerely,

James F. Jones, Chairman
Consumer Family Advisory Committee

Denise B. Little, Vice-Chairman
Consumer Family Advisory Committee

Tony Berry, Co-Chairman
New Beginnings Support Group

Position Statement
Mental Health Services of Catawba County Consumer and Family Advisory Committee
February 12, 2003

The Mental Health Services of Catawba County (MHSCC) Consumer and Family Advisory Committee (CFAC) reviewed and discussed all required parts of the Local Business Plan (LBP). This is a summary of our position on the LBP. Our report is attached to this summary. We continue to provide consumer oversight and input to this on-going reform process.

1. Our CFAC committee has been involved in planning and developing the LBP.

2. We support the current Service Management plan and will continue to review and comment on the plan as it is further developed.

3. We believe it is important to consumers that MHSCC move from Phase II to Phase III.

4. The Access Committee is in the process of identifying the access entry points. Once they are identified we will comment on any exceptions to the 30-minute, 30-mile rule for access.

5. CFAC supports the community collaborative effort as we stated in our last report. We will continue to watch and advocate for community collaboration as the plan is put into action.

6. We support MHSCC continuing to provide services until such time as qualified providers can be found to provide those services being divested.

Signed: _____
James F. Jones, Chairman Catawba County CFAC

Signed: _____
Denise B. Little, Vice-Chairman Catawba County CFAC

# Local Business Plan: Strategic Plan Matrix

| | |
|---|---|
| **Area Program(s)/County Program** | Mental Health Services of Catawba County |
| **Contact** | John M. Hardy, Area Director, (828)695-5900, fax (828)695-5949, johnh@catawbacountync.gov |
| **Submission Date** | 04/01/03 (revised from 01/02/03) |
| | |

**Item: I. Planning 3**

**Goal: The local business plan incorporates a 3-year strategic plan for initial implementation that has the necessary elements as outlined. (see page 14 of State Plan 2002 – Local Business Plan hard copy)**

**Effective Date: 04/04**

| Steps Taken | Steps Planned | Barriers |
|---|---|---|
| Open board meeting with staff, Area Board and Board of Commissioners and Dr. Visingardi<br><br>Sub-committee meeting with representation from Area Board, County Commissioners, county management and area program steering committee to make recommendations on governance model and phase of implementation to pursue in MH Reform.<br><br>Decision made by Area Board and County Commissioners to implement MH Reform in Phase II – January 2004. (addendum: formal resolution | | |

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| adopted by the Area Board in January 03 to change to Phase III implementation date based on continued lack of necessary information from the Division) (Attachment F)<br><br>Meetings with neighboring area programs to discuss possible collaborative efforts around LME functions. By mutual agreement of all parties involved, MHSCC will not seek to merge with another area program at the current time. Commitment to ongoing communication among surrounding area programs in order to determine the most efficient use of resources, keeping up with ongoing changes.<br><br>3/11 – Meeting with David Swann, Crossroads Area Program<br>4/02 – MHSCC Quality Management Team met with Blue Ridge Management Team<br>4/10 – Meeting with Rick French, Alexander County manager, Daryl Robinson, Foothills Board Chair, Tom Lundy, Catawba County Manager<br>4/15 – County manager meeting with Blue Ridge Area Program<br>4/17 – Meeting with John Alexander – Foothills Area Program Director<br>5/15 –Meeting with David Swann, Crossroads Area Program and Joel Mashburn, Iredell County Manager, Tom Lundy, Catawba County Manager<br>7/2 – Meeting with John Alexander – Foothills Area Director<br>10/3 – Meeting with David Swann, Crossroads Area Director<br>Additional meetings have been held<br><br>Letter of intent sent to the Division to remain a single-county area authority and to become an LME with limited service provision. (Attachment G)<br><br>Area director established steering committee responsible for oversight of local business plan.<br><br>Quality Management Team identified sub-committee | | |

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| chairs for each section of the local business plan.<br><br>Committees were formed with reports and products sent back to the steering committee in conjunction with the Quality Management Team.<br><br>Establishment of planning committee with 3 members of CFAC and all committee chairs involved in developing the local business plan.<br><br>Utilized community meeting format for presentations about education on MH Reform.<br><br>5/22 – Presentation at Hickory Rotary Club<br>10/14 –Presentation at Frye Regional Medical Center<br><br>Conducted provider and community forums to address planning needs. Publicized events through newspaper, radio, television and web site<br><br>9/16 – Community Forum<br>9/23 - Selected provider meeting<br>9/23 – Community Forum<br>9/30 – 2 provider meetings<br><br>Surveyed area providers and compiled results regarding current services provided and interest in future community service roles<br><br>Meetings held with local government officials to address planning needs<br><br>Multiple meetings with Tom Lundy, County Manager<br>3/19 – Meeting with Mick Berry, Assistant County Manager<br>9/4 – Meeting with Mick Berry, Assistant County Manager<br>9/24 – Meeting with Tom Lundy and Mick Berry and representative from steering committee<br>10/16 – Meeting with Mick Berry, Assistant County Manager<br>Additional meetings have been held | | |

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| CFAC sponsored consumer forum on 9/18 to identify consumer priorities<br><br>Quality Management Team outlined transitional steps for movement to a primary management role rather than a service provider role<br><br>A full review of all services provided directly and indirectly was conducted to determine the following: target population utilization rate, financial stability, community relations and impact, potential providers, current contracting arrangements, special considerations that may inhibit divestiture.<br><br>Submitted waiver request in April 03 to continue to provide services as we move forward with implementation of divestiture plan | **3 year strategic plan**<br><br><u>January 04 – June 05</u><br><br>Increase efforts to make all service programs financially self-sufficient (i.e. not dependent upon county funds or fund balance). This will be accomplished through reorganization as necessary and consolidation of services to maximize resources and minimize overhead. Independent financial viability will increase options of spin-out/spin-off or RFP packages as targeted on attached divestiture plan.<br>**Responsible party** – Quality Management Team<br>**Target Date:** June 2005<br><br>According to attached strategic plan timeline, seek waiver for continued service provision in those programs for which providers have not yet been identified or contracted according to attached strategic plan timeline. Ongoing efforts at divestiture will occur concurrently in the interim.(Attachment H)<br>**Responsible party:** Quality Management Team and Area Board<br>**Target Date:** April 2004<br><br>Strategize for organizational transition from service provider to local managing entity to include: development of staffing patterns for core clinical functions and strengthening of administrative functions including MIS capabilities and UM/UR.<br>**Responsible party**: Administrative Services<br>**Target date:** January 2004 | Salary rate and benefit packages for long-term staff factor heavily into disproportionate cost per service program versus revenue. Rate structures do not wholly support components of various services. This will be an on-going issue to maintain highly qualified staff for provider network.<br><br>Lack of cost modeling for core LME functions |

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| | Integrate case management under one level of supervisory oversight; cross-train in addition to specialized areas, retaining as a single unit under the LME to maintain service safety net for consumers.<br>**Responsible party**: Program Managers<br>**Target Date:** January 2004 | Staff areas of expertise will need to be expanded and supported, with subsequent increased training costs. |
| | Determine viability of "packaged options" for successful RFP of services. Services were grouped based on experience and clinical benefit for consumers. The goal of the LME is to minimize "cherry-picking" and maximize hubs for service provision rather than fragmentation throughout the community. Based on RFI results re-package services as needed to maximize divestiture options. Issue RFP's.<br>**Responsible party:** Quality Management Team<br>**Target Date:** April 2004 | Sufficient number of private practitioners for certain populations but currently a limited number of organizations capable of becoming a hub.<br><br>Potential hubs have little to no financial incentives for expansion of service roles. |
| | Maintain regularly scheduled meetings (e.g. DSS, Interagency Council, Children's Collaborative, Children's Alliance, etc.) with community providers to expand existing service capacity, or develop new service entities for identified community needs. Discussions and negotiations will include both current providers in the community as well as providers coming into the area.<br>**Responsible party:** Quality Management Team<br>**Target Date:** Ongoing | Potential reluctance of private providers to take on target populations due to Medicaid requirements for documentation and auditing, funding streams not sufficient for covering service delivery costs. |
| | As area program role transitions from service provision to primary management focus, continue exploring employment options for current staff both within the organization, other county agencies and | Must consider probability of significant gap in salary, benefits and retirement plans for long-term county staff transitioning to private or non-profit employment as area program divests itself of |

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| | as a consideration for contracted services in order to provide continuity of care for consumers. Maintain human resources issues as a priority in working with county government and in establishing RFP development<br>**Responsible party:** Quality Management Team<br>**Target Date:** Ongoing<br><br>Follow transition plan for non-targeted population as noted in previous column.<br>**Responsible party:** Program Managers<br>**Target Date:** April 2003 | service provision. |
| Identified those individuals currently served who are not in the target population to factor in transition plan<br><br>Determination made that as of January 2003 MHSCC will begin phasing in acceptance of only those clients meeting target population eligibility for services – non-target population will be referred to other resources or accepted under the "transitional non-covered population category" to be used for tracking purposes.<br><br>Transition planning for current consumers will follow the outline provi ded by Dr. Visingardi in the September 13, 2002 memorandum to Area Directors, Area Board Chairs and County Managers regarding: Service transition for individuals not included in MH State Plan Target Populations. (Attachment I)<br><br>Established policy on long-range planning | Develop protocol for training clinical staff on transition issues such as referrals to community resources, caseload management, communicating consistently with current clients who do not meet target population eligibility.<br>**Responsible party:** Quality Management Team<br>**Target Date:** April 2003<br><br>As detailed in the quality provider network section, assure provider network and community supports for non-targeted populations, as they will likely experience reform efforts first. | |

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| methodology (Attachment J) | **2nd year strategy**<br><br>Explore feasibility of spin-out/spin-off of service delivery programs | |
| | Issue RFP's for packaged services with criteria established by the county management, area program quality management team, CFAC, and area board. | Lack of standardized outcome expectations, quality care tracking tools from the Division necessary for thorough RFP provisions and on-going contract management. |
| | Continue development of LME core clinical and administrative functions | Cost modeling needs to be clarified by the Division for adequate planning and development. |
| | Continue to develop the QPN and work toward meeting community-identified service gaps | No fiscal supports for service providers to meet service gaps. |
| | Continue exploration with surrounding area programs regarding consolidation of LME functions and/or potential for complete or partial merger to obtain economies of scale. | Political concerns based upon different philosophies and investment as evidenced by county funding disparities. |
| | **3rd year strategy**<br><br>Continue exploration with surrounding area programs for potential merger opportunities | |

**Reviewers Comments:**

**Attachment F – Board resolution for Phase III implementation**
**Attachment G – Letter of intent concerning governance**
**Attachment H – Draft Service Divestiture Plan**
**Attachment I – September 13th memorandum from Dr. Visingardi**
**Attachment J –Long-Range Planning Methodology Policy**

# Resolution

**1/30/03**

**Whereas:** Mental Health Services of Catawba County wishes to ensure client stability throughout Mental Health Reform, and

**Whereas:** There is a lack of State produced information necessary to do clear, adequate, and comprehensive planning for the Local Business Plan, and

**Whereas:** The State has given Area Authorities and Counties the option to select the implementation date of its Local Business Plan, and

**Whereas:** This transition of public mental health, developmental disability, and substance abuse services to a more privately delivered model will require maximum information before such can take place smoothly, therefore

**Be it Resolved:** That the Board of Mental Health Services of Catawba County seeks to modify the implementation phase of LME Certification from the Phase II schedule of January, 2004, to that of Phase III, beginning in July, 2004. This decision was approved by Board action on January 30, 2003.

Signed David L. Isenhower 1/30/03

David L. Isenhower, Chairman Date

CATAWBA COUNTY
P.O. Box 389 • 100-A South West Boulevard • Newton, North Carolina 28658-0389 • Telephone(828) 465-8200
http://www.co.catawba.nc.us
FAX(828) 465-8392

September 24, 2002

Secretary Carmen Hooker Odom
2001 Mail Service Center
Raleigh, NC 27699-2001

Dear Secretary Hooker Odom:

This letter is the declaration of governance for the operation of mental health, developmental disabilities, and substance abuse services in Catawba County. In accordance with the requirements set forth in the Mental Health Reform legislation and the State Plan, the Board of Commissioners of Catawba County at its meeting on September 16, 2002, formally and unanimously adopted the following positions:

1. Catawba County will use the single county Area Authority model for the governance of its mental health related services. Although Catawba County does not meet the strict population thresholds outlined in the Bill, the Board of Commissioners feels very strongly that the single county program as operated in Catawba County is extremely responsive to citizen and client needs. The fact that Mental Health operates as a single county authority under the state statute means that it is considered a department of the County for budget and audit purposes. Its budget is fully detailed as a part of the County budget as opposed to being a line item as is the case in so many multi-county programs. The Mental Health program in Catawba County has high visibility in the community and with the Board of Commissioners and County Administration. We believe this visibility would be weakened if we were a part of a multi-county effort.

   We made the decision to continue to operate as an authority instead of a county program for several reasons. First, as mentioned earlier, Mental Health in Catawba County operates like a County department, thanks to the excellent working relationship between the Area Mental Health Board and the Board of Commissioners and all of the staff. Mental Health draws upon the County's Technology Department, uses the County's financial, payroll, and personnel systems and follows the County's pay, classification, personnel and benefit plans. Second, we fundamentally disagree with the provision in the state law under the County program model which requires that an advisory board appointed by the Board of Commissioners report to the County Manager. We think this is a flaw in the current legislation and believe it needs to be changed. Any citizen board appointed by the Board of Commissioners should report directly to the Board of Commissioners and not to county administration.

2. Catawba County's Area Authority will plan for the implementation of Mental Health Reform in Phase II, starting in January of 2004. We continue to be very concerned and disappointed that to this date the State has not been able to produce the necessary financial model and funding information needed to do effective local planning. This makes it difficult to plan with any degree of accuracy. We have already started the steps of involving the community and

clients as directed by the Mental Health Reform Legislation and will continue to do so, but it becomes increasingly difficult to prepare a business plan without the financial and funding information. Our choice to implement reform in Phase II is an attempt to give the State more time to provide this critical information so that we can do a better job with our local planning.

Our intentions are to assure that the citizens of Catawba County continue to have available to them the necessary services needed to respond to their various conditions of mental illness, developmental disabilities, and substance abuse services. We will implement as much of the State plan as is practical to assure these intentions.

Sincerely,

W. Steve Ikerd, Chairman
Board of Commissioners

David L. Isenhower, Chairman
Area Mental Health Board

pc: Richard Visingardi, Ph.D.
Mail Services Center
Raleigh, NC 27699-3001

Catawba County Board of Commissioners

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**DRAFT** Service Divestiture Plan

| Service | First year (Jan.'04- Dec.'04) | Second year (Jan.'05-Dec.'05) | Third year (Jan.'06-Dec.'06) |
|---|---|---|---|
| Respite – contracting has already been accomplished, with CCC | | | |
| Detox/ Transportation for Adult SA clients to be provided via contract with local and/or regional providers **Target date: January '03** | Accomplished | Accomplished | Accomplished |
| ECIS – (Child DD clients) | Move to Public Health or DEC in accordance with Health Plan **Target date: January '04** | | |
| Case Management (Adult and Child) including CAP/MR | Integrate case management under one level of supervisory oversight; cross-train in addition to specialized areas, retaining as a single unit under the LME **Target date: March '04** | Remain as part of LME | Remain as part of LME |
| Outpatient MH (Child)<br>Outpatient SA (Child)<br>Adolescent Sex Offender Program<br>Psychiatric Services | Package all child outpatient services with juvenile court contract ---- RFP or move to another public agency **Target date for RFP: April '04** | **Provider becomes operational: January '05** | |
| Smart Start | Explore all options for divestiture – possibly RFP singly, with other children's services, or move to another public agency **Target date for RFP: April'04** | **Provider becomes operational: January '05** | |
| Adult MH Outpatient<br>Adult SA Outpatient<br>Psychiatric services<br>SAIP – Adult<br>Adult EAP treatment | Package Outpatient MH/SA, court programs (ADETS, DWI), SAIP, psychiatric services and EAP treatment --- **Target date for RFI: July '04** | RFP, spin-off as a private nonprofit or spin-out under another vendor **Target date: January '05** **Provider becomes operational: July '05** | |

**DRAFT** Service Divestiture Plan

| Service | First year (Jan.'04-Dec.'04) | Second year (Jan.'05-Dec.'05) | Third year (Jan.'06-Dec.'06) |
|---|---|---|---|
| DD Residential and LifeSkills (Adult DD) | Seek waiver to continue operations as they currently are | Package DD Residential and Lifeskills, possibly along with some existing DD contractors---<br>Complete new building behind MH Main, and move into facility by July '04<br>**Target date for RFI: January '05**<br>RFP, spin-off as private nonprofit or spin-out under another vendor<br>**Target date for RFP: July '05** | **Provider becomes operational: January '06** |
| MH Residential<br>Connections<br>CSP (Community Support Program)<br>ACTT (ACT TEAM)<br>Psychiatric Services | Seek waiver to continue operations as they currently are | Package Connections, MH Residential,<br>CSP, ACTT, and psychiatric services--<br>**Target date for RFI: January '05**<br>RFP, spin-off as private nonprofit or spin-out under another vendor<br>**Target date for RFP: July '05** | **Provider becomes operational: January '06** |
| ACT Program | Seek waiver to continue operations as they currently are | Explore options with school system taking over<br>**Target date for RFI: March '05** | **Target date for RFP: January '06**<br>**Provider becomes operational: July '06** |
| LME ROLE | Core functions & limited service provision. Core functions consist of: Screening, assessment, referral, emergency triage and services, care coordination, service coordination, consultation, education and prevention | | Core functions, with case management as only service |

**RFI – Request for information**; informal solicitation from the community with the question "what might you be able to do with _____ services for _____people?"

**RFP – Request for proposal**; formal set of expectations set forth by the Area Program outlining details of what needs to be done. This becomes a statement of "We need you to do _____for _____people with the expectation of ….." ; this is a step closer to contract specifics

**"Packaging"** (as used in this grid) – combining services in a common space, with the collective effort to be financially self-sufficient (i.e., not requiring county funds or fund balance to keep financially viable)

Major Lease Expirations: First Plaza 3/31/05
CVCC 2/16/03

**North Carolina Department of Health and Human Services**
**Division of Mental Health, Developmental Disabilities and Substance Abuse Services**
3001 Mail Service Center • Raleigh, North Carolina 27699-3001
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Michael F. Easley, Governor
Carmen Hooker Odom, Secretary

Richard J. Visingardi, Ph.D, Director

September 13, 2002

MEMORANDUM:

To: Area Directors
Area Board Chairs
County Managers

From: Richard J, Visingardi, Ph. D.

RE: Service Transition for Individuals Not Included in MH State Plan Target Populations

There may be some confusion with respect to State Plan implementation and how area/county programs should address the transition of individuals to other community supports when individuals are not included in the target population. This is such a key issue in terms of service coverage that I need to reiterate the Division's position on the transition of individuals from area/county programs to community supports and the use of the "Transitional Non-Covered" target population groups used in the Integrated Payment and Reporting System (IPRS). The technical guidance provided herein is designed to ensure the needs of individuals are met through a measured and planned transition from services provided by the area/county program to other community supports, with as minimal disruption as possible. The Division will issue additional guidance in the near future to address clinical and best practice considerations for transitioning individuals into alternative community supports.

*The State Plan 2002: Blueprint for Change*, emphasizes that "Services to consumers and their families must not be disrupted by missteps in the implementation process" (page 61). In its description of transitions, the Plan further elaborates the following:

*"There are a number of individuals being served by the current system who do not met eligibility criteria for a target population. These people will be assisted to move to other alternatives within the system over a clinically appropriate but reasonable length of time. There are many community organizations across the state that have long histories of helping people who need human services and supports. The LME will promote and encourage membership of these organizations in this local provider network. These agencies who give so much to their communities will be important and respected partners in the statewide effort to provide services to the people who need them. Members of target populations who are already receiving services, but whose care, services and/or supports substantially exceed those indicated for their level of disability, must be reevaluated and the level of supports realigned in order to free up resources for others who are equally or more in need of services. (State Plan 2002, page 62)*

Guidance for technical considerations for area/county programs implementing State Plan Transition during SFY 03 is as follows:

SFY 03 (July 1, 2002 through June 30, 2003) has been designated as a transition year for implementing certain portions of the State Plan. Area/county programs should use this year to identify individuals already receiving services, or coming into services, during the current year but who will NOT fall within the target population groups as defined in the State Plan Chapter 3, Section - Target Populations. Within available resources, area/county programs MUST continue to serve these individuals during the year as transition to other community supports takes place.

If individuals being served in the current year do not meet criteria for the new target populations, area/county program clinicians are expected to carry out transition planing to transfer individuals to necessary community supports to ensure continued support and treatment. The goal for completing such transitions, with transitions occurring throughout the year, is June 30, 2003.

In order to ensure the availability of Division resources during this transition, the following funding decisions have been made for area/county programs phasing into IPRS this year:

1. For the period of time reporting continues within all of the current UCR systems, service eligibility will continue as it has in the past. This means that reporting within the current UCR systems is not limited to the target populations as set forth in the MH State Plan.
2. As area/county programs begin reporting services within IPRS, the Division has already established and communicated to area/county programs procedures for reporting services to individuals within the "Transitional Non-Covered" population category. While payments will not be generated through IPRS for the "Transition Non-Covered" population, utilization of the "Transitional Non-Covered" population category will accomplish two purposes - cash flow and year-end settlement:
   a. Cash Flow: In the event IPRS earnings for target populations are not sufficient to earn at approximately the 1/12$^{th}$ level, area/county programs may request additional payments during the year based on services to the "Transition Non-Covered" populations. Area/county programs will be able to utilize the value of services provided to "Transition Non-Covered" populations as justification to support bringing Division payments up to approximately the 1/12$^{th}$ per month level if IPRS actual payments are below this level. A more detailed outline of Cash Flow as it relates to "Transition Non-Covered" populations is outlined in the Hold Harmless material being distributed by the Division later in September 2002. Two items in Hold Harmless related to this are (i) addressing cash flow on a quarterly basis rather than monthly, and (ii) submission procedures for written requests for additional payments associated with cash flow needs.
   b. Year-End Settlement: While the IPRS system will not generate payments for the "Transition Non-Covered" populations during the year, services provided to this population and included in IPRS reporting will be taken into account in year-end settlement, either through allowable expenditures if settling on expenditures or, if settled on earnings, via the inclusion of the value of services reported to IPRS for this population but not paid via IPRS.

As noted above, individuals who do not qualify to receive services under any IPRS population category should be designated in the "Transitional Non-Covered" population category under the primary age/disability group that is most representative of the client's main focus of treatment or services. All IPRS claims submitted for clients enrolled in a "Transitional Non-Covered" population category would be denied as 'Ineligible to Receive Services' for payment purposes, however, services provided to this population will be factored in as outlined in 2.a. and b. above.

The "Transitional Non-Covered" population category will be used for tracking State Plan services provided to the transitional population by age/disability. Area/county programs and the Division will use the data collected on the transitional populations to report to the legislature the demographic, diagnostic, cost and other critical descriptive data elements for these populations. This will provide for necessary local, regional, and statewide analysis of the transitional populations and their service needs. The data may also be a factor in determining if the Division should alter one or more target populations to address additional individuals.

If you have any questions, please contact my office.

cc: Secretary Carmen Hooker Odom
Lanier Cansler
James Bernstein
Area Finance Officers
Executive Leadership Team
Rob Lamme
Gary Fuquay
Jack Chappell
Bob Duke
Gary Imes
Wanda Mitchell
Carol Duncan Clayton
Patrice Roesler

Mental Health Services of Catawba County

**POLICIES AND PROCEDURES**

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ACTIVITY: LOCAL MANAGEMENT ENTITY (LME)

SUBJECT: LONG-RANGE PLANNING METHODOLOGY

Number: 1.000
Effective Date: 10/17/02
Amended Effective:
Board Approved: 10/17/02
QMT Approved: 10/11/02

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POLICY:

It is the policy of Mental Health Services of Catawba County (MHSCC) to adhere to long-range planning methods that are consistent with Mental Health Reform initiatives. Ongoing efforts will prioritize divestiture of direct services, work toward efficient and effective management of public funds for MH/DD/SA Services, manage public policy, and develop strong community provider networks and supports with consumer/stakeholder involvement at all levels.

PROCEDURE:

1. Quarterly reports to the Division of MH/DD/SA will be generated addressing planning efforts of the area program toward comprehensively meeting LME certification requirements. This includes adequate consideration of transition efforts for consumers and staff throughout all stages of implementation.

2. Beyond LME certification status, planning will be maintained to maximize management roles in addressing community needs. Consumer Family Advisory Committee (CFAC), County Board of Commissioners, Area Mental Health Board, and community stakeholders will be active participants in the planning process.

3. MHSCC will implement and incorporate state-standardized components in planning which utilize outcome-based data in decision-making.

HISTORY NOTE: Approved by QMT on 10/11/02. Approved by the Mental Health Board on 10/17/02 and effective 10/17/02.